ULTRA Health Care Inc.

☐ INITIAL
☐ UPDATED

SPEECH THERAPY CARE PLAN

SOC DATE ___/___/___

TREATMENT DIAGNOSIS/PROBLEM _____

ONSET: ___/___/___

ANALYSIS OF EVALUATION/TEST SCORES _____

PLAN OF CARE SPEECH THERAPY: INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X".)

☐ Evaluation (C1)	☐ Aural rehabilitation (C6)	☐ Pain Management
☐ Establish rehab. program	☐ Non-oral communication (C8)	☐ Speech dysphagia instruction program
☐ Establish home maintenance program	☐ Alaryngeal speech skills	☐ Care of voice prosthesis including
☐ Copy given to patient	☐ Language processing	☐ removal, cleaning, site maintenance
☐ Copy attached to chart	☐ Food texture recommendations	☐ Teach/Develop communication system
☐ Patient/Family education	☐ Safe swallowing evaluation	☐ Trach. instruction and care
☐ Voice disorders (C2)	☐ Therapy to increase articulation,	☐ Retraining of cognitive, feeding, and perceptual skills
☐ Speech articulation disorders (C3)	☐ proficiency, verbal expression	☐ Teach safe/effective use of communication
☐ Dysphagia treatments (C4)	☐ Lip, tongue, facial exercises to	☐ device (specify): device
☐ Language disorders (C5)	☐ improve swallowing/vocal skills	☐ Other:

Note Each **Modality**, specify frequency, duration, amount: _____

OBSERVATIONS, INSTRUCTIONS AND MEASURABLE OUTCOMES: _____

EVALUATION AND PATIENT/CAREGIVER RESPONSE: _____

ADDITIONAL SPECIFIC SPEECH THERAPY GOALS (Note: Each Modality specify frequency, duration, amount) Locator # 22

PATIENT EXPECTATION	SHORT TERM — Time Frame	LONG TERM — Time Frame
☐ Patient will demonstrate improved reading/writing, use of gesture/numbers within _____ weeks.	☐ Patient will eating and drinking and taking all medications by mouth within ____ wks	☐ Patient will demonstrate functional communications, exhibit maximum verbal and sentence formulation and comprehension within disease limits w/ _____ weeks.
☐ Patient will demonstrate improved swallowing/chewing/oral/motor control within _____ weeks.	☐ Patient will increase accuracy of yes-no responses to greater than 80% accuracy within ____ wks.	☐ Patient will demonstrate appropriate use of functional VERBAL/NON-VERBAL communications system within _____ weeks.
☐ _____	_____	☐ _____

FREQUENCY AND DURATION _____ REHAB POTENTIAL ☐ Good ☐ Fair ☐ Poor

EQUIPMENT RECOMMENDATIONS _____

SAFETY ISSUES/INSTRUCTION/EDUCATION _____

PATIENT/CAREGIVER RESPONSE TO PLAN OF CARE _____

DISCHARGE DISCUSSED WITH: ☐ Patient/Family ☐ Care Manager ☐ Physician ☐ Other (specify) _____

CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ STA ☐ SS ☐ SN ☐ Other (specify) _____

APPROXIMATE NEXT VISIT DATE ___/___/___

PLAN FOR NEXT VISIT _____

DISCHARGE PLAN: ☐ When goals met ☐ Other (specify): _____

PLAN DEVELOPED BY: _____ (Therapist Name) _____ (Signature & Title) ___/___/___ (Date)

CARE PLAN REVIEW

DATE	REVIEWED/REVISED BY (signature/title)	COMMENTS

PART 1 - Clinical Record PART 2 - Patient's Home Folder

PATIENT NAME - Last, First, Middle Initial	ID#